



BOARD OF HEALTH
TOWN OF FOXBOROUGH
MASSACHUSETTS

BHP- _____
DATE REC'D _____
CHECK# _____

PLANNED OPENING DATE: _____

40 SOUTH STREET
Tel (508) 543-1207
Fax (508) 543-6278

(Application must be submitted at least 30 days before the planned opening date)

FOOD ESTABLISHMENT PERMIT APPLICATION

Establishment Name: _____		EMAIL: _____										
1. Establishment Address: _____												
2. Establishment Mailing Address (if different): _____												
3. Establishment Telephone No: _____												
4. Applicant Name & Title: _____												
5. Applicant Address: _____												
6. Applicant Telephone No: _____		7. 24 Hour Emergency No: _____										
8. Owner Name & Title (if different from applicant): _____												
9. Owner Address (if different from applicant): _____												
10.) Establishment Owned By:		11.) If a corporation or partnership, give name, title, and home address of officers or partner.										
<input type="checkbox"/> An Association <input type="checkbox"/> A corporation <input type="checkbox"/> An individual <input type="checkbox"/> A partnership <input type="checkbox"/> Other legal entity _____		<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Title</th> <th style="text-align: left; border-bottom: 1px solid black;">Home Address</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>		Name	Title	Home Address						
Name	Title	Home Address										
12.) Person Directly Responsible For Daily Operations (Owner, Person in Charge, Mgr., etc.):												
NAME & TITLE: _____												
ADDRESS: _____												
TELEPHONE NO: _____		FAX: _____										
EMERGENCY TELEPHONE NO: _____												
13.) District or Regional Supervisor (if applicable)												
NAME & TITLE: _____												
ADDRESS: _____												
TELEPHONE NO: _____		FAX: _____										
14.) Pest Control Co.: _____		15.) Sewage Disposal Private or Public										
Company Name: _____		Water Source Private or Public										
Address & Phone No: _____												
16.) Days & Hours of Operations: _____		17.) No. of Food Employees: _____										
18.) *Name of Person In Charge- Certified in Food Protection Management: _____												
19.) *Person Trained in Anti-Choking Procedures (If 25 Seats or More):												
Name: _____		Number of Seats: _____										

THIS APPLICATION MUST BE FILLED OUT COMPLETELY

*This is a checklist for your convenience.

The following documents must be returned with this application along with the fee/made payable to the Town of Foxborough 30 days prior to your opening date or upon the yearly renewal date. (by January 1)
(LATE FEES WILL APPLY IF NOT PAID BY THE BEGINNING OF THE YEAR)

- SERVE SAFE CERTIFICATION**
- ANTI-CHOKING CERTIFICATION (if 25 seats or more)**
- MENU with Consumer Advisory**
- Location of grease traps _____**
NAME OF HAULER: _____